SERFF Tracking Number:	*ULCC-125878895*	*State:*	*Arkansas*
Filing Company:	*The Union Labor Life Insurance Company*	*State Tracking Number:*	*40728*
Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*ULLGA-LF-0808*		
Project Name/Number:	*/*		

Filing at a Glance

Company: The Union Labor Life Insurance Company

Product Name: ULLGA-LF-0808	SERFF Tr Num: ULCC-125878895	State: ArkansasLH
TOI: L04G Group Life - Term	SERFF Status: Closed	State Tr Num: 40728
Sub-TOI: L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Karen Whitham, Carla Wallace	Disposition Date: 10/31/2008
	Date Submitted: 10/30/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Association, Discretionary, Trust, Other
Filing Status Changed: 10/31/2008	
State Status Changed: 10/31/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

The attached group life application form, ULLGA-LF-0808, is submitted for your review and approval. This form is new and will not replace any existing form. It will be used with group life insurance products that have been previously approved by your department. Variable provisions are bracketed.

SERFF Tracking Number:	*ULCC-125878895*	*State:*	*Arkansas*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*ULLGA-LF-0808*		
Project Name/Number:	*/*		

Coverage will be offered through direct response mail. No agent solicitation is involved.

This application is in final print format.

Should you have any questions or require any further information, please do not hesitate to contact me at 202-962-2901 or cwallace@ullico.com.

Company and Contact

Filing Contact Information

Carla Wallace, Compliance Analyst
8403 Colesville Rd
Silver Spring, MD 20910

cwallace@ullico.com
(202) 962-2901 [Phone]

Filing Company Information

The Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910
(202) 682-0900 ext. [Phone]

CoCode: 69744
Group Code: 781
Group Name:
FEIN Number: 13-1423090

State of Domicile: Maryland
Company Type: Life and Heallth
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$120.00
Retaliatory?	Yes
Fee Explanation:	1 form filed @ $120.00 = $120.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Union Labor Life Insurance Company	$120.00	10/30/2008	23584513

SERFF Tracking Number:	*ULCC-125878895*	*State:*	*Arkansas*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*ULLGA-LF-0808*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/31/2008	10/31/2008

SERFF Tracking Number:	*ULCC-125878895*	*State:*	*Arkansas*
Filing Company:	*The Union Labor Life Insurance Company*	*State Tracking Number:*	*40728*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*ULLGA-LF-0808*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/31/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ULCC-125878895*	*State:*	*Arkansas*
Filing Company:	*The Union Labor Life Insurance Company*	*State Tracking Number:*	*40728*
Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*ULLGA-LF-0808*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Form	Life Insurance Benefit Application		Yes

SERFF Tracking Number:	*ULCC-125878895*	*State:*	*Arkansas*
Filing Company:	*The Union Labor Life Insurance Company*	*State Tracking Number:*	*40728*
Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*ULLGA-LF-0808*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ULLGA-LF-0808	Application/ Enrollment Form	Life Insurance Benefit Application	Initial			ULLGA-LF-0808.pdf

UnionLaborLife

("We, Us, Our, the Company")

Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910
Executive Office: 1625 Eye Street, Washington, DC 20006

[Term Life] Insurance Benefit Application

[No. XXXXXXXXXXXX]
[Name]
[Address 1]
[Address 2]
[Anywhere, ST 00000]

Section I: Personal Information. Please tell us about yourself and your Spouse/Domestic Partner (DP), if applying:

Member

Date of Birth ____/____/_____ [State of Birth _____]

○ Male ○ Female [SSN: ____-___-_____]

Phone (___)_____ ○ Home ○ Work ○ Cell

[Driver's License# _____ State of Issue _____]

Email Address _____

Height_____ Weight _____
feet/inches lbs

[During the past 12 months have you used any tobacco products?

○Yes ○No]

Please provide the name, address, and phone number of your primary care physician below.

_____

_____

_____

[Spouse/DP Name

_____

Date of Birth ____/____/_____ [State of Birth _____]

○ Male ○ Female [SSN: ____-___-_____]

Phone (___)_____ ○ Home ○ Work ○ Cell

[Driver's License# _____ State of Issue _____]

Email Address _____

Height_____ Weight _____
feet/inches lbs

[During the past 12 months have you used any tobacco products?]

○Yes ○No

Please provide the name, address, and phone number of your primary care physician below.

_____

_____

_____]

Section II: Benefits Information. Please provide the following required information.

Member: ○ [$100,000] ○ [$50,000] ○ [$25,000]

Will this insurance replace or change any life insurance or annuity contract on your life? ○Yes ○No

Are you applying for any of the optional riders listed below?

[Waiver of Premium ○Yes ○No Accidental Death ○Yes ○No

Children's Term ○Yes ○No Hospital Accident ○Yes ○No]

Member Beneficiary Relationship

[Spouse/DP: ○ [$100,000] ○ [$50,000] ○ [$25,000]

Will this insurance replace or change any life insurance or annuity contract on your life? ○Yes ○No

Are you applying for any of the optional riders listed below?

[Waiver of Premium ○Yes ○No Accidental Death ○Yes ○No

Hospital Accident ○Yes ○No]

Spouse/DP Beneficiary Relationship]

Section III: Medical History. Please complete the following required information:

1. During the past 7 years, has a health professional evaluated, diagnosed or treated you for any of the following conditions? If "Yes", please provide details in Section IV:	**Member Yes**	**Member No**	**[Spouse/DP Yes**	**Spouse/DP No]**
a. heart attack, heart failure, irregular heart rhythm or heart valve disorder?	☐	☐	☐	☐
b. poor leg circulation (peripheral vascular disease)?	☐	☐	☐	☐
c. cancer including Malignant Melanoma, Hodgkin's disease, Leukemia?	☐	☐	☐	☐
d. a blood or bone marrow disorder, Human Immunodeficiency Virus (HIV) or Hepatitis C Virus (HCV)?	☐	☐	☐	☐
e. stroke, mini-stroke, Alzheimer's disease, Dementia, Multiple Sclerosis, Lou Gehrig's disease, Seizure or Epilepsy?	☐	☐	☐	☐
f. asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD) or sleep apnea?	☐	☐	☐	☐
g. kidney insufficiency, failure, or end stage renal disease?	☐	☐	☐	☐
h. liver failure, cirrhosis or hepatitis?	☐	☐	☐	☐
i. Diabetes, Ulcerative Colitis, Crohn's Disease, Rheumatoid Arthritis or Systemic Lupus Erythematosis?	☐	☐	☐	☐
j. anxiety and/or depression for which hospitalization was recommended?	☐	☐	☐	☐

2. During the past 5 years, have you (please provide details in Section IV):

a.	had surgery or been advised to undergo surgery, including weight reduction surgery?	☐	☐	☐	☐
b.	been told by a health professional to seek treatment for alcohol or drugs?	☐	☐	☐	☐
c.	sought or received Social Security Administration (SSA) disability benefits?	☐	☐	☐	☐
d.	been convicted for driving under the influence (DUI) or while intoxicated (DWI)?	☐	☐	☐	☐
e.	been declined or received an "extra premium" class rating for any life insurance policy?	☐	☐	☐	☐

3. During the past 12 months have you (please provide details in Section IV):

a.	consulted with any health professional for a health condition not mentioned above?	☐	☐	☐	☐
b.	Been advised to undergo a diagnostic procedure?	☐	☐	☐	☐

Section IV: Medical History Details.

A. If you answered "Yes" to any of the questions in Section III: Medical History, circle the condition and use the space below to provide complete details, including date of onset or occurrence, treatment, and physician information (attach a separate signed and dated sheet if needed). [*Example: COPD, 5/23/2006, Oxygen, Dr. James Smith, 123 Any Road, City, ST, Zip, (111) 111-1111.]*

Member: [Spouse/DP (if applying):

_____ _____

_____ _____

_____ _____

_____ _____]

B. Please list all medications you have been prescribed and/or have taken in the past 12 months.

Member: [Spouse/DP (if applying):

_____ _____

_____ _____

_____ _____]

Section V: Please read, sign, and date below.

[**California:** Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for purposes of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.]

[Texas Disclosure: The acceleration-of-life-insurance benefits offered may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.

Texas Disclosure: Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.]

[I understand and affirm by my signature below that, to the best of my knowledge and belief, the information in this entire application is true and complete. I understand that a separate Certificate will be issued to each applicant and that no insurance is in effect until I am issued my Certificate and my first premium is paid before my effective date and during my lifetime. I understand that if I fail to give true and complete answers on this application, benefits may be denied.

I understand that I may revoke this authorization at any time by giving the Company written notice of revocation.

To determine my insurability, or for claims purposes, I authorize any physician, medical practitioner, institution, VA Hospital, or other medically related facility, insurance company, the Medical Information Bureau, or any Consumer Reporting Agency to give any information about my physical or mental health to The Union Labor Life Insurance Company or its reinsurers. This authorization or its photocopy is valid for 24 months from the application date and I or my beneficiary may request a copy. I have read the applicable fraud notice on this application and the Notice to Applicant enclosed with this form as required by the Fair Credit Reporting Agency.]

→ _____ _____ [→ _____ _____
Member's Signature **Date** **Spouse/DP Signature (if applying)** **Date**]

[HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize my health care providers, including pharmacies and pharmacists, any person engaged in the sale or dispensing of prescription drugs, and any other person who prepares, collects or maintains health information about me to disclose all records pertaining to my receipt of health care services or supplies, including prescription drugs to The Union Labor Life Insurance Company ("the Company") to be used by the Company to determine my eligibility for insurance and any claim for insurance benefits. I acknowledge that the provision of health care services or supplies by a person authorized to make disclosure under this Authorization may not be conditioned upon my signing this Authorization; however, the Company may decline my application for insurance or my claim for benefits if I refuse to sign or revoke this Authorization. I further acknowledge that I may revoke this Authorization at any time by submitting a written revocation request to The Union Labor Life Insurance Company at [8403 Colesville Road, Silver Spring, MD 20910], but the revocation will not affect actions taken before receipt of the revocation or any legal right the Company has to contest my policy or certificate or a claim under my policy or certificate based on information obtained prior to the revocation. I understand that the information disclosed pursuant to this Authorization may be redisclosed and no longer protected by the privacy regulations under the Health Insurance Portability and Accountability Act. This Authorization will expire one year after the date of execution below.

→ _____ _____ [→ _____ _____
Member's Signature **Date** **Spouse/DP Signature (if applying)** **Date]**

Print Name:_____ Print Name:_____]]

SERFF Tracking Number:	*ULCC-125878895*	*State:*	*Arkansas*
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Product Name:	*ULLGA-LF-0808*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ULCC-125878895*	*State:*	*Arkansas*
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Product Name:	*ULLGA-LF-0808*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/29/2008

Comments:

Flesch Certification and Certification of Compliance are attached.

Rule & Regulation 49 - is not applicable to this application filing (the Guaranty Association notice goes with the policy/certificate). Policies and certificates issued to Arkansas residents will comply with Rule and Regulation 49, ACA 23-79-138, and Bulletin 11-88

Consumer Info Notice - is not applicable to this application filing (it goes with the policy/certificate).

Attachments:

Readability Certification.pdf

AR Certification Rule 19.pdf

Review Status:

Satisfied -Name: Application 10/29/2008

Comments:

Not Applicable

READABILITY CERTIFICATION

I certify that the following form submitted with this filing achieved the following scores using the Flesch Test Reading Score standards.

Form	Description	Flesch Score
ULLGA-LF-0808	Term Life Insurance Benefit Application	41.8

THE UNION LABOR LIFE INSURANCE COMPANY

By: _____

Title: James Messinger, Insurance Operations

Date: October 16, 2008

CERTIFICATE OF COMPLIANCE WITH ARKANSAS RULE & REGULATION 19

Insurer: The Union Labor Life Insurance Company

Form Number(s): ULLGA-LF-0808

I hereby certify that the filing above meets all applicable Arkansas requirements including the applicable requirements of Rule & Regulation 19.

James Messinger

October 30, 2008
Date